Wyoming Department of Health — Behavioral Health Division

Clinical Review Team (CRT) Request

Behavioral Health Division,
Developmental Disabilities Section
Phone (307) 777-7115
Fax (307 777-6047

Participant Legal Name: _____ Age: _____ Date Submitted: _____ Waiver: _____

Case Manager: _____ Participant Support Specialist Name: _____ Med ID #: _____

REQUEST INFORMATION

The Case Manager, in conjunction with the team members, shall provide justification for each service requested. The questions below shall be completed to give background information on the person's case and provide supporting information for the request. The Division may request more information, additional documentation, or information from other team members to support a request before it is reviewed by the Division. Upon completion of this request, submit this form and supporting documentation to the Participant Support Specialist for initial review.

For all Clinical Review requests, answer questions 1 through 3.

1. **Describe the reason for the Level of Service Need or Extraordinary Service or Support adjustment as specified in the Division's policy. Include factors or conditions that necessitate this request. Please be specific as to what Level of Service is being requested.**

_____

2. **If requesting Extraordinary Services, specify the units being requested on a daily or weekly basis based upon the needs of the participant. Please be specific and include the specific service and number of units being requested.**

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3. **Describe other non-waiver service options, such as natural and/or paid supports by a third party, which were explored to meet the participant's needs.**

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NOTE: If the request meets the criteria for the Clinical Review Team to review, the Participant Support Working Manager will refer the case to Clinical Review Team and the Division shall work with the Case Manager if additional information is needed.